MAINE EMERGENCY MEDICAL SERVICES
VERIFICATION OF EMT CERTIFICATION

Applicant Must Complete this Section. Please type or print legibly.

Current State License/Certification Number: _____ Date of Birth: _____

Name: _____ Social Security Number: _____

Section to be completed by the current certifying State EMS Office

Certification/License Number: _____ Level of Certificate/License: _____

Date Certificate/License was issued:_____ Expiration Date: _____

Has there been any suspension, revocation or disciplinary action taken against this certificate/license?

Yes _____ No _____ If yes, please explain: _____

_____

Has this individual ever been convicted of a felony? Unknown: ____ Yes ____ No ____

Was certification/licensure granted through reciprocity? Yes _____ No ____

If yes, from what State or National Registry _____

Course Completed:

- ❑ Basic EMT - Met or exceeded 1994 DOT Standards
- ❑ EMT-Intermediate - Met or exceeded 1999 DOT Standards
- ❑ EMT-Paramedic - Met or exceeded 1998 DOT Standards
- ❑ Other – Please explain or attach a copy of the curriculum

What are the minimum hours of training required by your state to obtain certification at this level? _____hours

Please indicate which of the following is included in training:

❒ Manual Defib ❒ IV ❒ ET ❒ Surgical Cric ❒ Needle Cric
❒ Med Administration ❒ Narcotic Administration

Do you know of any reason why EMS certification should be denied? Yes _____ No _____

If yes, please explain: _____

Verifying Person's Name: _____ Title: _____

Agency Name and Address: _____

_____

Insert completed original form in the self-addressed, stamped envelope provided by the applicant. Seal the envelope and sign across the back flap and mail to the applicant.